OSAH FORM 1

This form is available online at http://www.ganet.org/osah/form.html or by telephone request at (404)657-2800.)

OSAH USE ONLY DOCKET NUMBER:	AGENCY	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE
	DCH				

DCH MEDICAID RECIPIENT LEVEL OF CARE REFERRALS

FOR RECIPIENT CASES, CHECK ONE

☐ Denial of Level of Care ☐ Case Closure ☐ Reduction in Benefits
☐ Disputed determination of benefits ☐ Agency inaction ☐ Failure to act within reasonable time for benefit change
☐ Denial of expedited services ☐ Denial of opportunity to apply for benefits ☐ Other: If so specify: _____

COUNTY OF RECIPIENT'S RESIDENCE: _____

Date Notice of Adverse Issued: _____ **(ATTACH AGENCY NOTICE TO CLAIMANT OR COMPUTER COPY OF SAME)**

DCH Manual Procedures supporting Notice of Adverse Action: Manual Name _____**Chapter** _____**Section** _____

Date DCH received Claimant's Request for Hearing: ☐ **Oral on** _____ ☐ **Written on** _____

DCH Case Number or agency reference number: _____ **Benefit Continued During Appeal:** ☐ **YES** ☐ **NO**

MEDICAID RECIPIENT LEVEL OF CARE REFERRALS		SELECT ONLY ONE TYPE OF CASE
☐CCSP (Community Care Services Program) ☐ICWP (Independent Care Waiver Program)	☐KATIE (Katie Beckett deeming waiver) ☐LOC (Level of care for any Medicaid category not listed here)	☐MWP (Model Waiver Program) ☐PAP (Prior approval program) ☐Other, specify _____

CONTACT PERSON IN REFERRING AGENCY AND ATTORNEY FOR AGENCY

NAME:	**TEL NO:**	**FAX NO:**
CURRENT ADDRESS INCLUDING ZIP CODE ON HEARING REQUEST	**POSITION**	**EMAIL:** **PAGER:**
ATTORNEY NAME:	**TEL NO:**	**FAX NO:**
CURRENT ADDRESS INCLUDING ZIP CODE	**GEORGIA BAR NO:**	**EMAIL:** **PAGER:**

CLAIMANT

NAME:	**TEL NO:**	**FAX NO:**
CURRENT ADDRESS INCLUDING ZIP CODE:	**EMAIL:**	**AMBULATORY** **☐YES ☐ NO**
ATTORNEY NAME:	**TEL NO:**	**FAX NO:**
ADDRESS INCLUDING ZIP CODE:	**GEORGIA BAR NO:**	**EMAIL:**
PERSONAL REPRESENTATIVE (PARALEGALS MAY ACT IN THIS CAPACITY):	**TEL NO:**	**FAX NO:**
CURRENT ADDRESS INCLUDING ZIP CODE:	**RELATIONSHIP TO CLAIMANT:**	**EMAIL:**

INDICATE DOCUMENTS ATTACHED:

☐Copies of DCH Medicaid procedures used.
☐Notice of action issued, either a copy of summary determination or a copy of the contents of the notice
☐Budgets utilized, if applicable
☐Claimant's written hearing request
☐Other: (please specify document) _____